14. Other Factors

Jobs

The work patterns of the homeless are very important in determining how lack of income prevents them from getting housing. In a 1984 HUD report, economic conditions of the homeless were examined. Nationally, an estimated 20 to 25 percent of the homeless work, usually part time or on an irregular basis. An additional 30 to 35 percent receive some form of public assistance. The remaining 50 percent "subsist" by begging, selling blood, collecting cans, or scavenging for food.[1]

The work patterns of Utah's homeless were examined in the 1986 Task Force report. Nearly 75 percent of the homeless reported that they usually worked before they became homeless and an additional 20 percent reported sometimes working. Nevertheless, when asked if they were now working, only 20 percent reported they usually worked while 73 percent reported that they were looking for employment.

Recent point prevalence counts give us additional information concerning the work patterns of the homeless and they have been referred to earlier in this report.

The University of Utah reports in their 1995 study that:

One hundred sixty respondents (76.6% of valid responses) indicated that they are not currently employed for various reasons (see Table II). Of those, the average time since last worked was 2.2 years (see Graph III); 66 (44.0% of valid responses) worked part-time jobs, and 70 (45.8% of valid responses) worked temporary jobs. One hundred ten (73.3% of valid responses) reported that they did not receive benefits at their former job. One hundred twenty-one respondents (59.0% of valid responses) indicated that they are currently looking for work.

Unemployment rates are statistically different ($p<.05$) between the respondents who have been homeless greater than one year and those who had been homeless less than one year. Of those who had been homeless less than one year, 90 respondents (71.4% of valid responses) were currently unemployed at the time of the survey. This compares to 70 respondents who had been homeless greater than one year (84.3% of valid responses) and were unemployed at that time.

[1] *Report to the Secretary on the Homeless and Emergency Shelters* (Washington, D.C.: U.S. Department of Housing and Urban Development, May 1984), p. 26.

TABLE II: REASONS FOR LEAVING FORMER JOB (Unemployed Respondents Only)

Reason	*Count*	*% of Valid Responses*
Temporary work	28	16.0%
Laid off	24	13.7%
Physical/mental illness	22	12.6%
Quit	19	10.9%
Fired	18	10.3%
Problems with boss	11	6.3%
Moved	9	5.1%
Other reasons	44	25.1%

Of the respondents who were working at the time of the survey, 22 (44.9% of valid responses) said that they were working part-time and 22 (45.8% of valid responses) were working temporary jobs. When asked about benefits, 28 (66.7% of valid responses) indicated that they did not receive benefits at their present job. Thirty-two of those currently employed (71.1% of valid responses) liked their job, and 34 (73.9% of valid responses) thought they would keep their present job for a while.

Those respondents who indicated that they were homeless and unemployed tended to have been homeless for significantly longer than those who indicated that they were homeless and employed ($p<.05$). The average difference in time homeless was about 1.65 years.

Lois Collins, the well-informed human services writer for the *Deseret News*, wrote a perceptive column in early 1994 headlined, "Federal Funding Formula is Cheating the Hungry and Homeless Who Work."[2] Collins points out that allocating federal dollars for emergency shelter and food based on a formula relying too heavily on employment figures has meant a 39 percent cut in Salt Lake County's allocation of these dollars. Collins goes on to explain that, "Unfortunately, finding a job has not always meant that people don't need that type of emergency assistance. As many as half of the people staying in Salt Lake County's homeless shelters (depending on what time of year) are working."

"But an extremely tight housing market and escalating rents have kept them in the shelters. They can't get out of the shelter network because there's no affordable housing. Thus, the need for emergency shelter hasn't gone down in line with the creation of jobs." She goes on to argue that "food need is actually increasing."

[2]Lois Collins, "Federal Funding Formula is Cheating the Hungry and Homeless Who Work," *Deseret News*, 11 January 1994.

In the Task Force report, people who were homeless were asked the reasons for leaving their last job and the longest time worked at one job. Thirty-one percent of the male homeless reported that their last job was only temporary as compared to 15 percent of the women. A similar number of both homeless men and women report being fired from their last job, nearly 21 percent. Not surprisingly, the number of homeless women laid off was slightly higher than homeless males, 14 and 15 percent respectively. Perhaps the most surprising, the number of women fired for substance abuse, primarily alcohol, was nearly three times greater than the number of men fired for that reason.

The median length of time at one job for the homeless was 3.1 years, according to the Task Force Report. Interestingly enough, the ten year update in 1995 by the University of Utah found the average length of time spent homeless was 3.2 percent, so despite the resources spent on addressing the problem the stays have not shortened. Forty percent of those interviewed for the Task Force Report said they had worked less than three years at their last job. Interestingly, 19 percent reported having worked 8 years or more at one job.

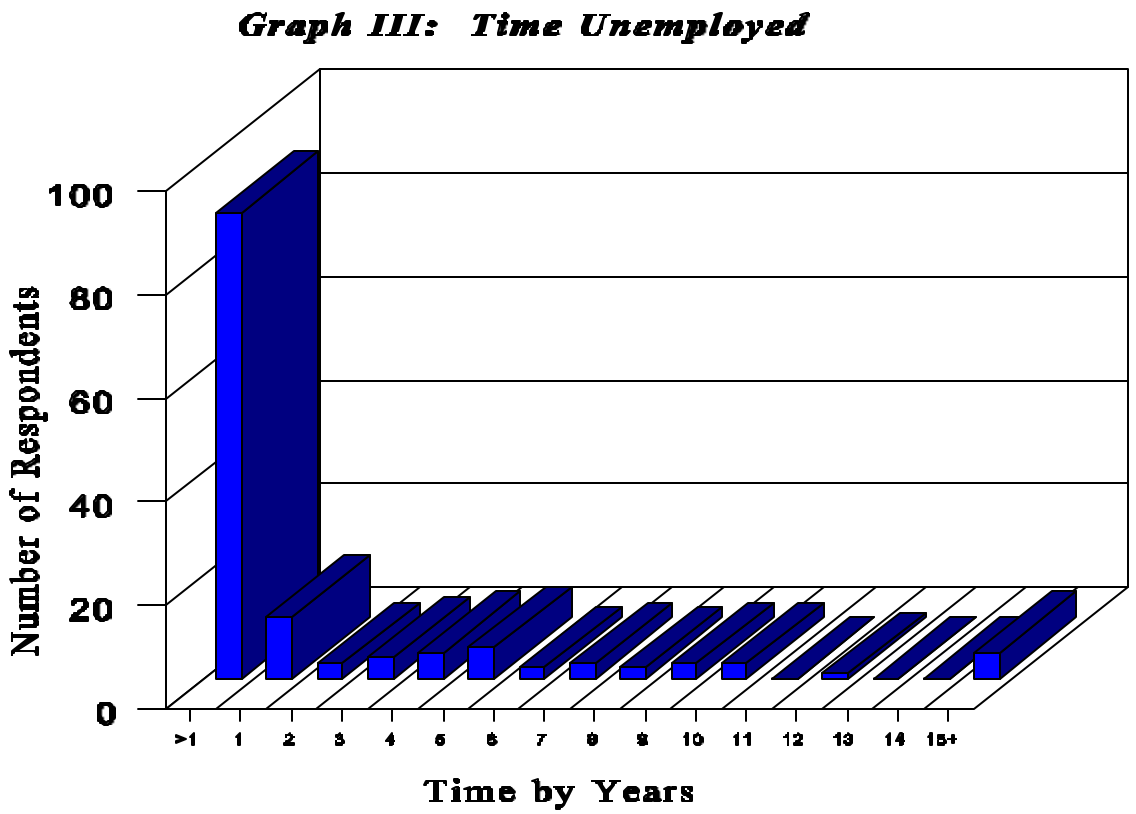
Perhaps one of the greatest perceived obstacles for the homeless in finding sufficient paying jobs is the lack of both practical skills and education. Nevertheless, upon examining the data collected by the task force in 1986 as well as national information, it appears to be just that, a perceived notion. According to the task force report, 33 percent of the homeless interviewed had completed high school and an additional 23 percent reported education beyond high school. Moreover, 60 percent of the homeless interviewed had the job skills necessary to work at one job three years or more.

In the 1990 Annual Report by the Interagency Council on the Homeless, the link between homelessness and low educational levels is virtually refuted all together. They wrote:

Although some studies suggest that low educational achievement is a major cause of unemployment among homeless persons--and therefore a partial cause of homelessness, itself--the educational achievement levels among homeless persons are virtually identical to those among the U.S. poor as a whole.

Ogden's Your Community Connection staff member Karen Thurber tracked the sources of income of homeless families for the months of June, July, and August 1993 and came up with interesting numbers.[3]

[3]Charles F. Trentelman, "Homeless But Not Hopeless," *Ogden Standard-Examiner*, 17 October 1993 pp. 1C-2C.



As mentioned earlier, other homeless persons resort to begging for subsistence. In an article that appeared in the *Salt Lake Tribune* on June 21, 1991, panhandlers were reported to make between $30 and $50 a day. It should be emphasized, however, that assuming most panhandlers are really homeless persons is not supported by any data.

Social Problems

Perhaps the most vulnerable to become homeless because of a reduction in income are female-headed single parent families. In a 1986 report to the Governor on poverty in Utah, it was reported that single female-headed households face almost 5 times the risk of being poor as male-headed households. Moreover, the percentage of female-headed families with children under 18 living in poverty increased from 36 percent in 1979 to 42 percent in 1984. The percentage of those with children under 6 living inpoverty increased from 52 percent in 1979 to 55 percent in 1984. Of those families living below the poverty line, 14 percent pay between 35 and 49 percent of their income for shelter and nearly 56 percent pay over half their income for shelter.

In addition to single parent families, the elderly are also at risk of becoming homeless. In 1983, 14 percent of persons age 65 and over had incomes below the poverty level. Nevertheless, because of the "safety net" available to the elderly, very few are forced into the street and become homeless.

Karen Thurber, then of Ogden's Your Community Connection, which provides services to homeless families, lists the following factors that she believes homeless families usually have in common:[4]

- They are commonly high school dropouts with poor literacy skills;
- They are unable to obtain employment that pays a livable wage due to poor or nonexistent job skills;
- They are divorced or separated with two or more dependent children and are not receiving child support;
- They are on welfare or earning less than $6 an hour;
- They have poor problem-solving skills, with a tendency to react to problems rather than anticipate them and take steps to avoid them;
- They have serious financial problems, including credit issues in collection or legal action. May have had, or are currently having, their wages garnished;
- They lack knowledge or understanding of tenant rights and responsibilities;
- They suffer from emotional instability that affect[s] daily functioning.

Labeling classes of people or making value judgments is generally not a useful way to get at the facts of a situation, but it is interesting to take the above list which suggests an underlying lack of life-coping skills and compare it to a special survey question Charles Rostkowski of St. Anne's Center asked homeless guests on the night of the 31 January 1993 count: "When you were growing up, did you live with: Your own parents; In an adopted family; Foster parents; An orphanage." Of 84 adults in the shelter that night, 75 answered the question. It was rather startling to learn that there were an abnormally high number of persons not raised by their own parents.

"Of the total, then, 25.4 percent were raised outside the home of their biological parents," writes Rostkowski. "That seems high, but I believe one would find similar percentages among other population groups outside the mainstream, in prison populations, for example. I haven't really thought what this data may mean. I only spoke briefly with someone in charge of foster care here in Weber County and she suggested that children are usually not placed in foster care unless a great deal of harm (both emotional and physical) has been done to them; they may be kids who because of this harm may find it difficult to develop adequate social skills and are, therefore, at greater risk to end up on the street."[5] At the very least these rather startling statistics reinforce the necessity of providing all children with nurturing and supportive environments where good life skills are modeled and taught.

There has since been scientific study brought to bear on Rostkowski's report. The authors of this report are grateful to Pamela J. Atkinson for bringing to their attention a report by Nan P. Roman and Phyllis B. Wolfe of the National Alliance to End Homelessness called *Web of Failure: The Relationship Between Foster Care and Homelessness*. "In the late 1980s," Roman and Wolfe write, "the National Alliance to End Homelessness (the Alliance) began to hear from service providers around the country that a seemingly disproportionate number of homeless people had a foster care history." The Executive Summary of this report lists six principle findings:

[4]Charles F. Trentelman, "Homeless but not Hopeless," *Ogden Standard-Examiner*, October 17, 1993, p. 2C.

[5]Charles Rostkowski, February 12, 1993, to Kerry William Bate.

- There is an over-representation of people with a foster care history in the homeless population.
- Homeless people with a foster care history are more likely than other people to have their own children in foster care.
- Very frequently, people who are homeless had multiple placements as children: some were in foster care, but others were “unofficial” placements in the homes of family or friends.
- Those people with a foster care history tend to become homeless at an earlier age than those who do not have a foster care history.
- Homeless people who are white are somewhat more likely to have a foster care history than people who are Hispanic or African American.
- Childhood placement in foster care can correlate with a substantial increase in the length of a person’s homeless experience.

This report suggests the following reasons for this linkage:

- The foster care system can fail to adequately deal with problems caused by sexual or physical abuse, or troubled or dysfunctional families.
- The foster care system can fail to adequately deal with physical or mental health problems of children.
- Caregivers assigned b y the foster care system can be abusive.
- Multiple placements can preclude the development of nurturing bonds that have been shown to be critical to normal personal development.
- Institutionalization can be established as the normative life style for children in the foster care system.
- Children in foster care may be unable to establish support networks that can carry over into adulthood.
- The foster care system can fail to help its wards achieve educational and training goals.
- Foster care may improperly prepare children for emancipation.
- Children in foster care may have difficulty making the transition from a dependence mode to an independence mode.

“All sources of data,” the report concludes, “support the primary finding that people with a foster care history are over-represented in the homeless population. Numerous sources, including the data collected from individual homeless people, indicate that there is an intergenerational aspect to the problem. Also, there is a strong indication that unofficial placements with relatives and friends often supplement official placements and lead to a series of multiple placements which can be very disruptive to a child’s development.”

Mental Illness

Most sources estimate that approximately 30 percent of homeless people are mentally ill, and all agree that mentally ill homeless are victimized by assault, are more likely to be picked up by the police, and too often dismissed by the mental health system with the assertion their aberrant behavior makes them "non-compliant." But recently progress has been made in promoting the idea that systems should be adapted to meet the needs of the mentally ill, and not the other way around.

Many observers point to the deinstitutionalization during the 1950s and '60s to explain the increase in the number of mentally ill homeless. In fact, in 1955 approximately 559,000 patients were in state hospitals in the United States. Today, that number has fallen to 114,000. In addition, according to the 1990 annual report by the Interagency Council on the Homeless, the number of days per "inpatient treatment episode dropped from 99 days in 1969 to 37 days in 1986; and outpatient, community-based care of the mentally ill increased from 379,000 episodes of outpatient care in 1955 to 5.6 million in 1986." Moreover, the number of beds in Utah's state hospital has fallen from 1,500 in the 1950s to slightly over 300 today. It is estimated that nearly 1.6 percent of all Utahns are either developmentally disabled or mentally ill.[6]

Deinstitutionalization alone does not account for the increase, but the way it was implemented may. Richard Lamb in a report entitled, *Homelessness* wrote:

> It is my feeling, however, that problems such as homelessness and criminalization of the mentally ill are not the result of deinstitutionalization per se but rather of the way deinstitutionalization has been implemented. A lack of understanding of the needs of the chronically mentally ill, plus the unplanned discharge of hundreds of thousands of mentally ill residents of state hospitals into inadequately prepared communities, added up to disaster.[7]

The problems facing homeless mentally ill individuals are very perceptively stated by Alan I. Leshner *et al.*, who wrote that "severely mentally ill individuals, in particular, cannot negotiate a service system in which health care, mental health and substance abuse treatment, social services and income support, legal services, housing, and rehabilitation and employment services are separate and uncoordinated. In addition to being comprehensive and integrated, the system of care we are promoting must be accessible to and easily maneuvered by its intended users."[8] The problem is compounded because "some people who are difficult to treat effectively are essentially dismissed by the treatment system."[9] This has been as true in Utah as in other places, with one mental health provider quoted as defending his agency's lack of commitment to the homeless mentally ill on the grounds that "these people are too sick for our system!"

The most extensive research that has been done concerning the mental health of Utah's homeless was done by the Task Force for Appropriate Treatment of the Homeless Mentally Ill in 1986. Volunteer interviewers were recruited from agencies serving the homeless or mentally ill and received training in interviewing.

Three indicators were used by the interviewers to determine the mental health of the person being interviewed. These include the DuPuy General Well Being Schedule, history of mental health treatment, and the interviewers' general impression.

Quoting from the task force report:

> The DuPuy General Well Being Scale has been recognized as a valid and reliable instrument which measures emotional health/psychiatric impairment on six dimensions: energy level; relaxed vs. tenseness; degree of satisfaction with life; cheerful vs. depressed mood; emotional/behavioral control;

---

[6]*Comprehensive Mental Health Plan of Services for the Seriously Mentally Ill, Blueprint For Action 1989-1991* (Utah State Mental Health Planning Committee, December 1988), p. 8.

[7]Richard Lamb, *Homelessness, Critical Issues for Policy and Practice* (The Boston Foundation, 1987), p. 33.

[8]Alan I. Leshner *et al*., *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness* (Washington, D.C., Interagency Task Force on the Homeless, 1992), p. xi.

[9]Alan I. Leshner *et al*., *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness* (Washington, D.C., Interagency Task Force on the Homeless, 1992), p. 9.

freedom from worry.

Using the DuPuy General Well Being Scale, the task force reported that 38 percent of the respondents were judged to be severely distressed and an additional 19 percent scored moderately distressed. Only 43 percent were judged to be in the positive well-being range. In addition, of those who were judged to be severely distressed, 62 percent also reported a physical problem.

The Task Force also reported that women were more likely to be distressed to some degree than were men. Only 33 percent of the homeless men interviewed were judged to be severely distressed as compared to 58.5 percent of the homeless women. Moreover, the number of male homeless that were scored in the positive well-being outnumbered those female homeless by nearly 25 percentage points.

It is also interesting to note that according to the Task Force report, those staying at a shelter scored lower than those who stayed elsewhere. Only 36 percent of those staying in a shelter were judged to be in the positive well-being range, as compared to 52.6 percent of those who stayed elsewhere.

Twenty-two percent of the homeless reported having been a patient at some time in a mental health facility. Of those nearly a third had been a patient during the past year. Nevertheless, in 1989, 839 homeless mentally ill persons were being treated at Utah's community mental health centers. In addition, 23 percent of the persons surveyed were "judged by the interviewers to be currently exhibiting symptoms of mental illness." Of those, nearly 59 percent scored severely distressed on the DGWB and only 29 percent were judged to be in the positive well-being range.

The recent point-in-time counts also provides further data concerning the homeless mentally ill, but as Martha Burt points out, mentally ill homeless are more likely to be on the streets than housed in shelters.[10] Between five and seven percent of the sheltered homeless are judged by providers to be chronically mentally ill. It is reasonable to conclude that the chronic mentally ill, for one reason or another, often do not seek shelter. Nationally, according to HUD, 23 percent of the mentally ill are "non-users" of shelters. When this is added to the percent of sheltered homeless judged to be mentally ill in both January and July, the results are similar to both national averages and the 1986 Task Force report.

A profile in the *Salt Lake Tribune* of case aide LeRoy Cook of Valley Mental Health Storefront quotes Mr. Cook as saying that for mentally ill people to get government benefits "is long and tedious and if someone is dealing with other things in their lives, it can be treacherous." Nevertheless, in 1993 Cook helped 137 people apply for Supplemental Security Income, Medicaid, Food Stamps or welfare, and estimates an eighty-five percent success rate.[11] Valley Storefront is an unusually informal program, perhaps in part reflecting it's delightfully individualistic program manager, Mary Hitchcox, who has built a very client-oriented agency serving the homeless mentally ill.

[10]Burt, p. 8.

[11]Anne Wilson, "S.L. Mental Health Storefront Helps Homeless Cut Red Tape for Benefits," *Salt Lake Tribune*, January 14, 1994.

The University of Utah study in 1995 revisited the issue of homelessness and mental illness. They report:

> The interviewers were trained in determining whether the respondents showed signs of mental illness. The survey instrument included a list of 34 common symptoms of mental illness including poor concentration, extreme disorganization, confusion, difficulty distinguishing what is real, and unusual speech or mannerisms. Interviewers were directed to check any symptoms they observed. It was estimated that those persons exhibiting four or more of such symptoms most likely had some type of mental illness. While this in no way provides a diagnosis of the mental health of the respondents, it does give a general sense of the mental well-being of those surveyed.
>
> With that in mind, 101 people interviewed (47.6%) showed no symptoms of mental illness, while only 59 (27.8%) exhibited four or more symptoms. The difference in the number of symptoms exhibited by male versus female interviewees was not statistically significant ($p>.05$) nor was the difference in the number of symptoms exhibited by respondents older than the median survey age of 38 and those 38 and younger ($p>.05$). These results coincide nicely with number of respondents indicating that they have been treated for mental illness: 49 respondents (25.0% of valid responses) answered affirmatively.
>
> Interviewers recorded a significantly higher number of symptoms for unemployed respondents than for employed respondents ($p<.001$). On average 1.23 more symptoms were recorded for unemployed respondents. Only three (6.1%) of the employed respondents exhibited four or more symptoms, while 46 (28.9%) of unemployed respondents exhibited four or more symptoms. This result is also significant ($p<.01$) indicating a likely higher incidence of mental illness among the unemployed homeless. Clearly, the causality associated with this result must be carefully considered before making conclusions: mental illness may prevent unemployment, but unemployment may also cause additional symptoms of mental illness.

The State Division of Mental Health has shown leadership in the State by providing quality assurance to the community mental health centers and assisting them to help meet the wide range of needs for housing and homelessness faced by the people with mental illness in the state. The relationship with the Housing Authorities, State Housing Office and Community and Economic Development and other resources in the state have been strengthened to assure mental health centers collective needs are included in planning, financial availability and policy development. Also, the quality of care for the people with mental illness who are in supported housing has been enhanced by developing "Preferred Practice Guidelines II" for quality assurance and specific guidelines for housing and case management services.

Adequate Supported Housing for the Seriously and Persistently Mentally Ill, (SPMI) adults continue to be the single most identified need for the state mental health system. This is true for both urban and rural areas, and across the service areas of the state. The housing situation continues to be critical and with the out-of-date estimate of 1.6 percent of all Utahns either developmentally disabled or mentally ill, according to the Comprehensive Central Health Plan of Services for the Seriously Mentally Ill, Blueprint For Action 1989-1991, Utah State Mental Health Planning Committee, December 1988. P. 8, with the population increasing the housing situation is now overwhelming.

The housing situation in Utah is so critical that low-income rentals are now priced out of reach of low-income tenants. Utah continues to see dramatic increases in housing costs, as new housing has not only appreciated dramatically in a market with housing shortages and increasing growth, there are increased restrictions on new housing which further rises the costs.

The mental health centers are reporting needs across the spectrum with emphasis on twenty-four hour care facilities. Also Community Mental Health Centers have developed moderate and minimum care housing programs which include transitional housing, and low-income independent supported housing in the

community to help meet the critical needs of people with mental illness.

Rural areas of the state are also somewhat unique in that the biggest upsurge in homelessness initially was in rural counties. Also many rural counties are unwilling to establish low-income housing because of the fear they will attract "undesirables." This resistance and lack of funding at the central housing authorities make it very difficult to coordinate housing services for people with mental illness in rural and frontier areas of the state, although some communities are accepting the need for affordable housing. The rural Mental Health Centers are reporting estimated housing needs for FY99-2000 of over (300) three-hundred beds Statewide.

Also, in order to assist the people with mental illness the State Division of Mental Health has applied and has received a formula grant, Projects for Assistance in Transition from Homelessness (PATH). This formula grant program is provided by the Federal Center for Mental Health Services under the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (P.L. 101-645, Title V, Subtitle B, Part C) for the purpose of providing services to individuals who are suffering from serious mental illness or who also have co-occurring substance abuse disorders, and who are homeless or at imminent risk of becoming homeless. Ending homelessness among persons with mental illness requires supported housing. Other housing models, such as group homes and transitional apartments are helpful for some clients for some length of time, but only permanent, affordable houses from which people are able to access individualized supports will ensure successful transitions from homelessness for most people with serious mental illness. For FY99-2000 the urban mental health centers are reporting having approximately 150 homeless people with mental illness and the rural mental health centers are reporting for FY99-2000 having approximately 100 homeless people with mental illness of which PATH funding will help to provide some of the needed services.

Under the leadership of Robert Snarr of the State Division of Mental Health, Community Mental Health Centers (CMHC) have identified the housing and homeless needs of their clientele as of fall, 1998:

> The following report is a quick snapshot that includes brief descriptions of the immediate housing needs identified by the ten Community Mental Health Centers, (CMHC's) in the State of Utah for FY99-2000. For each of the CMHC's the need varies from having a placement in a supervised setting where mental health services are available 24 hours a day/7 days a week to a moderate or low contact setting in which the person with a mental illness can live in the community with mental health services available at least one-time every 90 days.
>
> The ongoing housing needs of people with mental illness are extensive in Utah. The CMHC's have responded favorably in developing many mental health housing programs due to limited resources, (e.g., limited funding for homeless people with mental illness, limited funding through HUD and that Utah continues to see increasing growth with dramatic increases in housing costs), to help people with mental illness learn the skills to live and work in the community.

RURAL MENTAL HEALTH CENTERS

> Central Utah Mental Health is a comprehensive mental health center providing a continuum of services in the six county areas of Sanpete, Juab, Millard, Sevier, Wayne, and Piute. Given the difficulties of providing needed mental health services and housing to such a geographically large area with a sparse population it has become more difficult to secure and provide affordable housing to people with mental illness. As a frontier mental health center, Central Utah Mental Health has worked closely with the local community as well as with other service providers to help develop two supervised housing programs. The current immediate housing needs are estimated at 65, out of which at least 12 individuals are homeless.
>
> Four Corners Mental Health provides comprehensive mental health services in the county areas of Carbon, Grand and Emery. Four Corners Mental Health has one supervised mental health housing program in Moab however the need for affordable housing options are extensive. The highest need

includes families with mental illness in jeopardy of losing their mobile homes due toincreased lot rents, and housing and/or shelter for homeless men with mental illness as the nearest men's shelter is more than 120 miles away. The current immediate housing needs are estimated at 40, out of which at least 20 individuals are homeless.

Northeastern Mental Health provides comprehensive mental health services to Uintah, Daggett, and Duchesne counties. In FY97 local county officials, mental health and substance abuse advocates, and volunteers formed the tri-county Mental Health and Substance Abuse Authority in collaboration with the Department of Human Service of the State of Utah. An Inter-local agreement as provided by state law was signed, a tri-county board was established, and the new entity was created. Northeastern Mental Health currently has one mental health housing program and the current immediate housing needs are estimated at 50, out of which at least 12 individuals are homeless.

San Juan Mental Health provides comprehensive mental health services in San Juan County and the needs of San Juan Mental Health are extensive for housing issues. Currently San Juan Mental Health does not have a residential center or housing stock and therefore must use the services of other Mental Health Centers within their catchment areas. However, services provided include searches for appropriate housing situations for people with mental illness and include teaching skills development within the homes to help individuals maintain in the community. The current immediate housing needs are estimated at 75, out of which at least 50 individuals are homeless.

Southwest Mental Health provides comprehensive mental health services providing a continuum of services in the five county areas of Beaver, Iron, Washington, Garfield, and Kane. Southwestern Utah continues to grow at a rate greater than most other areas of the state. During the five-year period from July 1, 1991 to July 1, 1996, Washington County increases in population by approximately 39% to a total of 73,161. Iron County increased by 26% reaching a total population of 26, 875. Southwest Mental Health has developed several supervised mental health housing programs. The current immediate housing needs are estimated at 90, out of which at least 12 individuals are homeless.

URBAN MENTAL HEALTH CENTERS

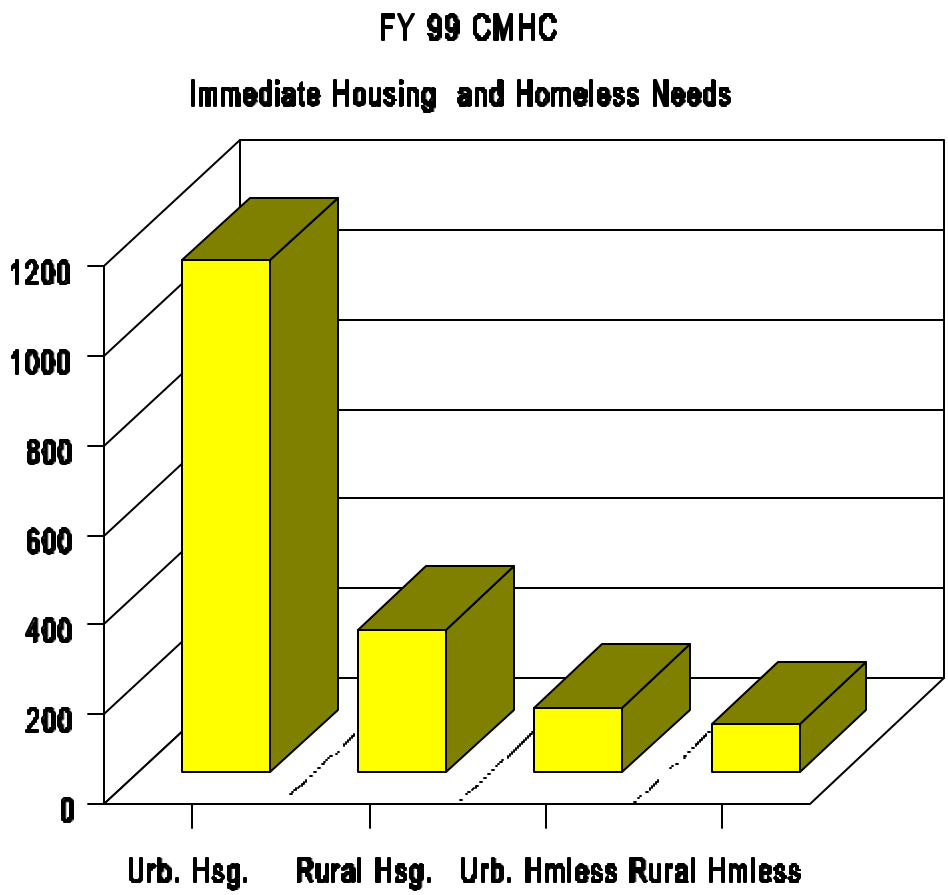
Bear River Mental Health provides comprehensive mental health services in the Box Elder, Cache, and Rich Counties. With an increasing population growth Bear River Mental Health has developed three supervised mental health housing programs in Logan and Brigham City. Also, Bear River Mental Health has recently purchased land in Brigham City to provide additional apartment units. The current immediate housing needs are estimated at 60, out of which at least 4 individuals are homeless.

Davis Mental Health is located in Layton and provides comprehensive mental health services to the Davis County area. Davis Mental Health operates and maintains four mental health housing programs for people with mental illness. Davis Mental Health is working on the development of additional housing through land acquired and there are ongoing efforts to find other affordable housing options. The current immediate housing needs are estimated at 400, out of which at least 12 individuals are homeless.

Wasatch Mental Health provides comprehensive mental health services in the Utah and Wasatch County areas. Utah County has a population of 318,000--the second highest in the state as of 1996. It also has the fourth highest population density at 160 people per square mile. Wasatch County is generally designated as a rural service area with a population of 13,000 as of 1996. The largest city is Heber City, with a population estimated at 5,299 as of 1996. The county is experiencing spillover population growth and housing development as property prices rise in nearby Summit County. Wasatch Mental Health works closely with the local community and has developed several supervised housing programs to assist people with mental illness. The current immediate housing needs are estimated at 160, out of which at least 25 individuals are homeless.

Weber Mental Health provides comprehensive mental health services in a multi-county district providing mental health services to residents of Weber and Morgan counties, consisting of a combined population of approximately 187, 920 residents. Weber Mental Health works closely with the local communities and has developed several supervised mental health housing programs. Also, in conjunction with PAAG, Weber Mental Health has been able to provide additional affordable housing options. The current immediate housing needs are estimated at 100, out of which at least 25 individuals are homeless.

Valley Mental Health Center provides comprehensive mental health services in the Salt Lake, Tooele and Summit Counties which has the highest population in the state. As Valley Mental Health serves approximately one-half of the states population of people with mental illness, they have developed several supervised mental health housing programs. Also Valley Mental Health has recently developed Safe Haven which will allow 25 homeless people with mental illness to find shelter in some studio apartments while they gain the skills to make the transition from the street to more permanent housing. The current immediate housing needs are estimated at 425, out of which at least 80 individuals are homeless.



This graph is a snapshot which shows the immediate housing and homeless needs, identified by the 10 CMHCs for FY 99.

Physical Health

In addition to the mental well being of the homeless, physical health is also of great concern. In a thoughtful column, Lois Collins explains why: "He searched for work but couldn't find it. And he knew why. His teeth were visibly rotting, the result of poor nutrition and hygiene. Life is like that, he said, when you live on the streets. No one actually said, 'Greg, I won't give you a job because you haven't seen a dentist in who knows how long.'" Collins goes on to point out the difference Wasatch Homeless Health Care Clinic has made for people with bad teeth, infections, sprained ankles, or tuberculosis.[12]

[12]Lois M. Collins, "Underfunded Clinic Provides Vital Services for S.L. Homeless," *Deseret News*, June 14, 1994; also see "Nurses Offer Health Tests for Homeless," *Deseret News*, February 22, 1994.

The most common diseases and illnesses afflicting the homeless are infections and injuries. An outbreak of syphilis was reported at Pioneer Park in late 1993, a place where many homeless persons congregate.[13] In addition, tuberculosis is believed to be 25 to 100 times more prevalent among the homeless population than among the general population. For a long time the tuberculosis issue was essentially unaddressed, as city, county, and non-profit providers wrestled with who was responsible and the county health department refrained from seriously pursing non-compliant tuberculosis-infected persons. Relationships improved when Dr. Silvia Corral, primary physician at Wasatch Homeless Health Care, became a member of the City-County Health Department Board. Since then this problem has received serious attention from the Health Department,[14] and in some cases non-compliant persons have been quarantined.[15] Apparently this is quite unusual in the United States—at least a story about two homeless men being taken into custody for failure to take their tuberculosis medicine earned a paragraph in *USA Today*.[16] By late October 1993, 26 new cases of tuberculosis had been reported, and another 10 patients from the previous year were still being treated. Three of these people had a new, drug-resistant strain of tuberculosis. The crying need now is for housing and hospital beds for those under treatment—a goal that was set in 1992 and not accomplished.[17]

The 1986 task force report showed that health care was a moderate concern for the homeless. On a scale of zero to six (six being very important) better medical care was ranked as 3.5. The task force survey also reported that 44 percent surveyed reported having a physical problem. Of those, 32 percent said the health problem was chronic. Physical ailments also seemed to be associated with age. Of those homeless aged 26 or younger, only 22 percent reported a physical problem as compared to 34 percent for those 44 years of age or older.
Of the physical problems reported by homeless persons, the three cited most frequently were back pain,

---

[13]According to Jennifer Brown, manager of the Utah Department of Health's sexually transmitted disease program, nine cases of syphilis were reported between July and September 1993, boosting the year-to-date total to 18, the same as the total number of cases reported in 1992. "Most of the cases came out of Pioneer Park, either an exchange of sex for drugs or sex for money," according to Ms. Brown. Dr. Silvia Corral, medical director of the Fourth Street Clinic run by Wasatch Homeless Health Care, said law enforcement had "pushed the drug-seeking and selling community to Pioneer Park. Therefore, the homeless population is an easily victimized and very vulnerable population to increased trafficking of drugs in their community" (see Anne Wilson, "Vices at S.L. Park Spawn Rash of Syphilis," *Salt Lake Tribune*, 24 November 1993). Law enforcement has had a difficult--some may say thankless--struggle with the problem of drug abuse in this area; pushing the problem into Pioneer Park was one way to get it away from the front doors of homeless shelters and soup kitchens.

[14]Nancy Hobbs, "More Homeless Taking Their TB Medicine," *Salt Lake Tribune*, 8 November 1993; this story especially credits Mark Winegar, "a street-savvy outreach worker--formerly homeless himself", who "is credited with boosting the continued treatment of 22 homeless people with TB on the Utah streets.... Winegar, ferrets homeless patients out wherever they may be--at shelters, friends' homes, under viaducts, living out of cars. He lets them know, in no uncertain terms and sometimes rough language, that their treatment is a life-or-death concern."

[15]Sheila R. McCann, "State Detaining Some TB Victims for Mandatory Doses of Medicine," *Salt Lake Tribune*, 27 October 1993. "We are going to attempt to be more aggressive in treating people," explained Assistant Att. Gen. Douglas Springmeyer, and Gayle Williamson, epidemiologist of the City-County Health Department explained "it's a last resort. We try everything else first. Most people are very cooperative when they have a communicable disease." In another story Ladene Larsen, Utah's bureau director for Chronic Disease Control, says "at any given time we have three to six people who are difficult to find and aren't willing to go along with the program" (*Provo Daily Herald*, 19 August 1993).

[16]Under "Utah. Salt Lake City," *USA Today*, 28 October 1993.

[17]Sheila R. McCann, "State Detaining Some TB Victims for Mandatory Doses of Medicine," *Salt Lake Tribune*, 27 October 1993; also see "Health Officials Ask for TB Facility," *Daily Spectrum*, 19 August 1993.

infections, and other muscular-skeletal problems. In addition, the Task Force reported that four persons had cited "heart trouble, seven epilepsy, five diabetes, six lung problems, four kidney problems, three high blood pressure, three ulcers, and two ulcerative colitis."

The Wasatch Homeless Health Care Program (WHHP), funded by the Stewart B. McKinney Act and local contributions, reports that "Among the 6,500 different homeless patients seen by WHHP in 1990, 3,470 (53 percent) were staying in Salt Lake area shelters, and 3,030 (47 percent) were doubling up with friends or relatives, living in cars, single-room-occupancy hotels (SROs), abandoned buildings, outlying camps, or were in alcohol and drug treatment facilities. These figures have not changed significantly since. WHHP estimates that 65 to 70 percent of the homeless people in the Salt Lake area are in need of primary health care services for acute or chronic illnesses, dental services, prescription medications, or for transportation to medical referral services on any given day."[18]

The Report goes on to say that "The most common diagnoses and health care issues for Utah's homeless individuals are as follows: among homeless children ages 0 to 17, respiratory problems and ear and eye complaints are most common. Health care providers in the past two years have seen more children who are experiencing developmental delays and failure to thrive. Among adults 18 and older, acute respiratory illness, acute and chronic musculoskeletal disorders, dermatological, cardiovascular, podiatric problems, substance abuse problems and lacerations/abrasions [sic] are problems most often seen."

Tuberculosis is also seen as a serious problem by Wasatch Homeless Health Care: "Tuberculosis, a poverty-related illness that is showing a resurgence throughout the United States, has become a pressing public health care issue among Utah's homeless since 1990. State Health Department officials predict that Utah will see about 80 incidents of TB in 1992, with approximately half of the cases coming from among the homeless population. There is a pressing need for temporary and transitional housing for those suffering from this public health disease."

Additional information concerning the health of the homeless is provided by the State Health Department TB screening. Of the 435 persons screened for TB, nearly 24 percent were on some type of medication. They ranged from acne medicines to high blood pressure medication to insulin to anti-depressants to tranquilizers.

Our point prevalence counts do not reveal the extent of physical health care needs among the homeless. Between 2 and 7 percent of the sheltered homeless were judged to have a physical handicap. The discrepancy between the point prevalence surveys and both the task force and State Health Department survey is the wording of the question, limiting it to only handicapped persons, and the subjective observations of those filling out the surveys.

This was another area where the University of Utah 1995 study was especially helpful.

UNIVERSITY OF UTAH REPORT ON PHYSICAL HEALTH

When asked whether they were in good health, 149 respondents (71.6% of valid responses) answered affirmatively. Forty-seven (22.6% of valid responses) responded that they had not been sick within the past year; 73 (35.1% of valid responses) had been sick once within the past year; 52 (25.0% of valid

[18]Allan D. Ainsworth, Ph.D., "Wasatch Homeless Health Care Report," 22 October 1992.

responses) had been sick three or more times. Forty-five respondents (28.7% of valid responses) indicated that they had experienced a serious or life-threatening illness within the past year. There was no significant statistical difference ($p>.05$) in health between men and women.

There was significant difference between the self-perceived good heath of those at or below the median age of 38 and those above ($p<.05$) with the younger group reported being sick nearly twice as much in the past year as did the older group. This strange result is driven by a high frequency of sickness reported by respondents in their 20's. The distribution of frequency of sickness by age is bi-modal with modes at about 28 and 65.

The self-perception of health was also significantly different by employment status ($p<.05$) with 32.3% of unemployed respondents indicating that they did not consider their health to be good while 16.3% of employed respondents responded in this manner.

Forty-two respondents (20.3% of valid responses) claimed that at some time in their life they had been seriously ill and were not able to receive treatment. Of those, 19 (37.3%) stated that the reason they did not receive treatment was that they could not afford it.

The number of respondents claiming permanent or persisting disabilities was 82 (41.8% of valid responses). This is somewhat higher than the 1986 survey, in which 31.5% of respondents reported having chronic health problems. There was no significant statistical difference ($p>.05$) between men and women as far as permanent disabilities. Likewise, there was no significant difference between those who have been homeless greater or less than one year. There was, however, a significance difference in claims of permanent or persisting disabilities between those who indicated they were employed and those who indicated they were not ($p<.01$). Only 24% of employed respondents indicated such disabilities while 47% of unemployed respondents indicated these disabilities.

Of the women surveyed, 39 (63.9% of valid responses) indicated that they had access to pre-natal care. The survey instrument did not ask whether they had need of such services.

One hundred twenty-five respondents (68.3% of valid responses) indicated that they had been tested for HIV. This seems alarmingly high, yet can be explained by the large number of people within this population who regularly sell their blood products. Only 1 respondent (0.8% of valid responses) indicated that the HIV test was positive.

Substance Abuse

Perhaps the most visible and most well known characteristic of the homeless is of substance abuse, but it is reassuring that a recent national study suggests that homelessness itself doesn't increase addiction.[19]

By far, the most abused substance by the homeless, not unlike the general population, is alcohol. National surveys estimate that between 35 and 40 percent of the homeless suffer from chronic alcohol problems. In addition, 10 to 20 percent of the homeless have chronic problems with drugs other than alcohol.

[19]"Homelessness Alone Doesn't Spur Addiction," *Deseret News*, 3 September 1993. This study was performed by the University of California, Los Angeles, School of Medicine. "Essentially, this study shows that homelessness is not the main risk factor for substance abuse," according to Dr. Lillian Gelerg, UCLA assistant professor of family medicine and head of the research team.

The homeless population in Utah seems to follow the national trends. According to the 1986 task force report, 32 percent of those homeless persons interviewed were judged to have an alcohol or drug abuse problem. Nevertheless, homeless persons failed to recognize a need for treatment. Only 14 percent agreed strongly that they needed help and only 12 percent reported seeking help in the past year while only 20 percent sought help sometime in the past. In addition, on a scale of 0 to 6 (6 being the most important) treatment for alcohol received only 1.1.

Drug abuse was reported even less frequently. Only 5 percent of the homeless surveyed in 1986 agreed they needed help for a drug problem and only 2 percent sought help in the past year, while only 7 percent had sought help sometime in the past. Receiving treatment for drug abuse was ranked only .3 on the same scale as above.

The point prevalence surveys present additional information concerning substance abuse among the homeless. Between 21 and 39 percent of the sheltered homeless are judged to have a drug or alcohol problem. In addition, HUD estimates that nearly 19 percent of alcoholics and drug abusers do not seek shelter. Therefore, these homeless persons are more visible in street locations.

Again, this was a special study area of the University of Utah in 1995. They found that “One hundred nineteen respondents (65.0% of valid responses) indicated that, before becoming homeless, they did not have a problem with alcohol; 50 respondents (27.3% of valid responses) said that they developed a problem with alcohol since becoming homeless. No significant statistical difference was found ($p>.05$) between male and female respondents as far as having an alcohol problem before becoming homeless. However, more males responded affirmatively to the question of whether they had developed an alcohol problem since becoming homeless: 34.1% of valid male responses compared to 10.7% of valid female responses.”

“One hundred thirty-three respondents (72.7% of valid responses) did not have a drug problem before becoming homeless; 30 respondents (16.5% of valid responses) indicated that they have had a problem with drugs since becoming homeless.”

Veterans

"I just disagree with the term that society uses for 'the homeless,' especially with veterans," said Ray Masterson, Vietnam veteran, "By God, we're in America. This is our home. We might be houseless Americans, but we're home."[20] The National Coalition for the Homeless reminds us that "from a historical perspective, homelessness among veterans is not a new phenomenon. After every war since the Civil War, there have been a number of dislocated servicemen..."[21] National studies indicate that about "one-third of single men who are homeless have served in the United States armed forces," and "the federal government estimates that between 150,000 and 250,000 veterans are homeless on any given night, and that possibly twice that many experience homelessness over the course of a year."[22] The National Coalition for the Homeless says that "Veterans become homeless for the same reason that other Americans become homeless—they can't afford to pay their rent. As housing costs have gone up, incomes have declined. In an increasingly tight housing market, a crisis such as the loss of a job, physical or mental illness, or substance abuse can push those already living on the margin into the streets. Some veterans have combat-related mental

[20]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), introductory statement.

[21]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), p. 1.

[22]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), p. ii.

and physical disabilities which increase the likelihood that they will become homeless."[23]

This problem has generated a good deal of emotional debate, with one advocate charging before a congressional committee that, "It is reasonable to characterize many homeless veterans as 'refugees,' displaced by war, with no country that will accept him and no nation that will provide him with asylum."[24]

The National Coalition raises two issues specific to veterans:

- A number of Vietnam veterans suffer from Post Traumatic Stress Disorder (PTSD) which increases the likelihood that they will become homeless. Treatment for PTSD is unavailable in many communities, and in many cases VA hospitals have been slow to recognize or unwilling to treat veterans with PTSD.
- Approximately one-half of veterans who are homeless have a problem with alcohol or drugs. Many veterans turn to alcohol or drugs when PTSD symptoms go untreated. Veterans are much more likely to abuse alcohol than other illegal drugs. There are waiting lists for alcohol and drug treatment programs in virtually every community.[25]

The National Coalition for the Homeless raises six issues which they believe are inadequate responses to this problem, charging the VA with (1) an "extremely mediocre" performance (in a survey the Coalition did of homeless veterans, the average rating of the VA by respondents was 5.24 on a scale of 0 to 10), (2) inadequate discharge planning which leads to VA hospitals regularly releasing "veterans who have completed residential treatment programs to the streets or shelters", (3) an inability to work with buyers defaulting on VA loans; (4) being unwilling to make repossessed housing available to the homeless: "of an estimated 6,800 empty foreclosed VA homes, only 6 have been obtained through the VA's program to make these properties available to those seeking to provide services and shelter to homeless veterans,"[26] (5) inadequate funding for programs targeted at homeless veterans—"one-tenth of one percent of the VA's total budget"; (6) inadequate job training programs targeted to homeless veterans—only 1.9 million dollars annually for the entire country.[27]

---

[23]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), pp. ii-iii.

[24]1 Million Veterans are Homeless and many are Disturbed, Experts Say," *Deseret News*, 9-10 May 1991, p. 4A. The "one million homeless veterans" figure seems high.

[25]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), pp. ii-iii.

[26]The source for this is the Interagency Council Annual Report, p. 255 (see Alker and Jacob, p. 22).

[27]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), p. iv. However, the Veterans Administration does have some programs which have been cited as models, such as the Dallas Domiciliary Care for Homeless Veterans Program, which received the Community Council of Greater Dallas 1991 Program Excellence Award ("VA Assists Thousands of Homeless Veterans--One at a Time," *Vanguard: U.S. Department of Veterans Affairs* [March 1992], p. 8).

That these problems are also Utah problems is demonstrated in the report referred to above, where Salt Lake City was one of twelve cities "reporting higher proportions of veterans in their homeless population."[28] Though no city in Utah was part of the communities the National Coalition for the Homeless especially surveyed, the Utah point prevalence counts also provide information concerning homeless veterans. According to the 1986 survey of homeless persons, nearly 41 percent were reported to be veterans. Of those, 59 percent were Vietnam-era veterans.

Our point prevalence counts show the number of *sheltered* veterans in the homeless male population:

Date	***% Veterans***
01/31/91	20%
01/31/92	22%
01/31/93	28%
01/31/94	37%
01/31/95	31%
01/31/96	40%
01/31/97	15%
01/31/98	17%

If, as is suspected, veterans are more likely to have mental health and substance abuse problems, then the numbers will be under-counted in shelters because those populations are least likely to take advantage of shelters. We can cross-reference these counts with demographics from Wasatch Homeless Health Care, which shows that during the first eleven months of 1993, 17.5 percent of the males and .3 percent of the females receiving services were veterans.[29] According to an Associated Press story in the *Provo Daily Herald*, "In Salt Lake City, most [veterans] avoid federal programs for veterans turned off by bureaucracy."[30]

Most of these, because of the median age of the homeless population, are likely veterans of the Vietnam era. The count from the 1986 survey can be considered a more reliable estimate of the homeless that are veterans because of the direct interaction and questioning of homeless persons as compared to a subjective estimate by homeless facility operators.

Steve Becker, former social worker for the Veterans Administration Medical Center, did outreach among the homeless. "We used to go to the homeless camps. But the veterans are there for good reasons," he explains. "They don't want anything to do with the VA. I have vets who have camped out for years. One has camped out for 10 years I know of on the Snake River in Idaho. But it is a tough way of life and dangerous and when they tire of it, we want to be here." Becker found six hundred veterans in 1993, and was able to help many

---

[28]Joan Alker and Andy Jacob, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington, D.C.: National Coalition for the Homeless, November 1991), p. 3. The report cites as a reference Laura D. Waxman and Lilia M. Reyes, *A Status Report on Hunger and Homelessness in America's Cities: 1990* (Washington, D.C.: U.S. Conference on Mayors, December 1990). Laurie Sullivan, "Vietnam Vet Finds and Helps His Brothers Under the Viaduct," *Salt Lake Tribune*, 11 July 1993 profiles VA critic Dave Browne, founder of the Vietnam Veterans Protective Alliance whose "mostly 'one man' organization" sometimes go under the viaducts to locate veterans. Browne complains that the VA system is "so overly regulated with their own rules that they spend all day just protecting these rules and the vet can just wait, or better yet, go away." His newspapers have been banished from VA premises "because his organization is not accredited by Congress."

[29]See "Table 2. Selected Demographics and Other Information N = 4,325 Homeless Patients N = 9,928 Medical Encounters Seen From January 1, 1993 - November 30, 1993 Wasatch Homeless Health Care Program, SLC Utah, December 27, 1993."

[30]Sonya Ross, "Study Offers Portrait of Homeless in U.S.," *Provo Daily Herald*, 20 December 1993.

with life-changing services.[31]

Entry/Exit Points for Homeless Individuals in Shelters

Perhaps the most intriguing look at the causes of homelessness comes from a survey instrument designed by Patrick Poulin of Travelers Aid Society and used by homeless and low-income providers throughout the state from 19 July to 31 July 1992 to track homeless persons.

Called "Steps Out of Homelessness" by its designer, it has been popularly called "Chutes and Ladders" because of the many pitfalls to successfully getting out of homelessness. Instead of looking at the *place* of origin, the instrument attempts to track institutions that are discharging more persons into homeless shelters than they are rescuing from such shelters. As Mr. Poulin explains, "Along the continuum of human needs is a series of services and resources. Unfortunately, the continuum of services and resources is not without gaps. In the housing arena, while the continuum of human needs is fairly basic, the resources and gaps between resources can be great—thus homelessness. To end homelessness we must first recognize the needs in relation to the present resources and services (housing/service community inventory) to identify both the gaps in services as well as the breadth of the gaps."[32]

Note that in this study, twice as many people entered the homeless shelter system (516) as exited (254) during the last two weeks of July 1992. This may partly reflect the end-of-the-month financial stress very low-income families feel.

When the institutional origins of homeless persons in shelters (emergency shelters, safe house/women shelters, family shelters, and transitional housing) is compared with where they go when they leave homeless shelters, the results are very interesting, as shown in the next graph, the result of a special study project in July 1992.

Once the number of women returning to their homes from safe houses/women's shelter's are discounted, it is apparent that many more people are coming from their own private housing as are finding their way back into such housing; jails are also releasing many people into homelessness. On the other hand, it appears that transitional housing, emergency shelters, and subsidized housing are serving many more people than they are discharging back into homelessness. This suggests that there should be more resources available to prevent foreclosures as a way to prevent homelessness, as well as some careful planning with jails and hospitals around discharge policies. On the other hand, there needs to be more alternatives for those large numbers coming from the streets who end up returning to the streets, including more transitional housing and better targeting of subsidized housing resources.

In an article entitled "Homeless Policy: Expansion During Retrenchment", Donna Kirchheimer lists eight public policies which have either contributed to the increase in homelessness or have failed to respond to the increase. She lists: (1) cuts in federal funding; (2) maximum rent allowances; (3) real estate collection and foreclosure policies; (4) tax abatement for private developers; (5) zoning of land; (6) regulating or failing to regulate redlining by banks; (7) regulating or failing to regulate the warehousing of vacant apartments; and (8) rent regulation.

[31]Robert Bryson, "Utah VA Gives Homeless Vets Needed Help," *Salt Lake Tribune*, January 4, 1994.

[32][Patrick Poulin], *Steps Out of Homelessness* (Salt Lake City: 22 April 1992), p. 1.